STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155741	A. BUILDING _____ B. WING _____	C 05/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTHCARE	**2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00106595. This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00105617 completed on 3/21/12. This visit was in conjunction with a PSR to the Investigation of Complaint IN00102099 completed on 1/19/12. This visit was in conjunction with a PSR to the Recertification and State Licensure Survey and Investigation of Complaint IN00103094 completed on 2/17/12. Complaint IN00106595 -Unsubstantiated, due to lack of evidence. Survey dates: May 2 and 3, 2012 Facility number: 004700 Provider number: 155741 AIM number: 100266630 Survey team: Karina Gates, BHS TC Beth Walsh, RN Courtney Mujic, RN Barb Hughes, RN Census bed type: SNF/NF: 44 Total: 44 Census payor type: Medicare: 2	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	Continued From page 1 Medicaid: 39 Other: 3 Total: 44 Sample: 3 Friendship Healthcare was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint IN00106595. Quality review 5/07/12 by Suzanne Williams, RN	F 000		